

# 2007 Medical Plan Summary

## Premera Blue Cross/Blue Shield (BCBS)

### Levels of Coverage:

Tier I Employee Only

Tier II Employee & Spouse/Registered Partner

Tier III Employee & Children

Tier IV Employee, Spouse/Registered Partner, & Children

**R&C = Reasonable and Customary Charge**

	Deductible			Covered Expenses		Annual Out-of-Pocket Maximum (includes deductible)		
	Tier I	Tier II & III	Tier IV	Plan Pays	You Pay	Tier I	Tier II & III	Tier IV
In-Network	\$250	\$250 per person \$500 per family		100% Certain Services 80% After Copay & Deductible	\$20 Office Visit \$100 Hospital Then 20%	\$2,250	\$2,250 per person \$5,500 per family	
Out-of-Network				60% R&C	40% after deductible, plus costs over R&C			
Lifetime Maximum				\$2,000,000 per covered individual				

This benefit description is intended to be a brief outline of coverage and is not intended to be a legal contract. Benefits are described more fully in the plan document, which is available for review at the Battelle office that administers this Plan for you. In the event of a conflict between the plan document and the description provided herein, the terms of the plan document will prevail. This material is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. Reasonable effort is made to have this material represent the intent of the Plan language. However, the plan document stands alone and is not considered as supplemented or amended in any way by the explanations or examples included in this material.

MEDICAL EXPENSES COVERED			
Description of Medical Plan Coverage		Premera BCBS Plan	
		In-Network	Out-of-Network
Ambulance	Charges for professional ambulance services to or from the nearest hospital.	\$75 copay then covered at 80% after deductible for emergency only.	\$75 copay then covered at 80% of R&C after deductible for emergency only.
Cosmetic Surgery – Elective	Charges for elective cosmetic surgery.	Not covered.	Not covered.
Dental Services	Charges for dental work necessitated by accidental injury to natural healthy teeth while covered under this Plan.	Covered at 80% after deductible.	Covered at 80% of R&C after deductible.
Durable Medical Equipment (DME)	Charges for rental or purchase of durable medical equipment (DME).	Covered at 80% after deductible.  Medical Equipment/ Prosthetics / Medical Supplies combined annual limit of \$10,000.	Covered at 60% of R&C after deductible.  Medical Equipment/ Prosthetics / Medical Supplies combined annual limit of \$10,000.
Education and Training	Charges in connection with custodial care, education or training, including orthoptic or vision training.	Covered at 100% per calendar year to a maximum benefit of \$250.	Not covered.

## MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Premera BCBS Plan	
		In-Network	Out-of-Network
Emergency Health Services	Emergency care, including Hospital Emergency Room, Alternate Facility, or Urgent Care Center.	\$75 copay (waived if admitted). Then covered at 80% after deductible.  <u>Urgent Care Center</u> : covered in full after \$25 copay.	\$75 copay (waived if admitted). Then covered at 60% after deductible.  <u>Urgent Care Center</u> : covered at 60% of R&C after deductible.
Excess of Reasonable and Customary (R&C)	For charges made which are in excess of R&C charges as determined by this Plan.	Participant not responsible for charges by in-network providers over and above the contracted allowable charges.	Not covered.
Experimental Procedures, Investigational or Unproven Treatment or Supplies	For services, treatment or supplies which are experimental, investigative, or unproven in nature.	Not covered.	Not covered.
Eye Examination	Eye exams received from a health care provider in the provider's office. One vision exam covered each calendar year.	\$20 copay per visit then covered in full  Limited to one examination per member per calendar year.	Covered at 60% of R&C after deductible.  Limited to one examination per member per calendar year.
Felony/Illegal Occupation/Riot	Charges incurred as a result of a felony, illegal occupation or voluntary participation in a riot.	Not covered.	Not covered.
Gender Reassignment	Charges for or in connection with sex change, transsexual surgery and/or treatments related to or leading to transsexual surgery.	Not covered.	Not covered.
Hospice Care	Hospice care that is recommended by a Physician and the care is received from a licensed hospice agency.	\$100 copay per admission then covered at 80% after deductible with the following maximums: <ul style="list-style-type: none"> <li>• Inpatient: 1 month;</li> <li>• Respite Care: 240 hours; 6 month limit</li> </ul>	\$100 copay per admission then covered at 60% of R&C after deductible with the following maximums: <ul style="list-style-type: none"> <li>• Inpatient: 1 month;</li> <li>• Respite Care: 240 hours; 6 month limit</li> </ul>
Hospital – Inpatient	Charges for hospital bed and board, limited to the hospital's most common semi-private daily rate. See "Mental Health/Substance Abuse" for other limitations.	\$100 copay per admission then covered at 80% after deductible.	\$100 copay per admission then covered at 60% of R&C after deductible.
Hospital - Outpatient	Charges by a hospital for medical care and treatment on an outpatient basis. See "Mental Health/Substance Abuse" for other limitations.	\$100 copay per admission then covered at 80% after deductible.	\$100 copay per admission then covered at 60% of R&C after deductible.
Hospital – Preadmission Testing	Charges for preadmission testing prior to hospital confinement.	See hospital benefits.	
Infertility Services	Charges for diagnosis and treatment of infertility.	Not covered.	

## MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Premera BCBS Plan	
		In-Network	Out-of-Network
Injections (Therapeutic)	Charges for injections received in a Physician's office when no other health service is received (i.e., allergy shots).	Covered at 80% after deductible.  Physicians Services copay may also apply.	Covered at 60% of R&C after deductible.  Physicians Services copay may also apply.
Laboratory Services and X-rays	Diagnostic and screening x-rays and laboratory services; x-ray, radium and radioactive isotope treatment; oxygen and other gases and administration thereof; blood transfusions and blood not donated or replaced; anesthesia and its administration.	Covered at 80% after deductible.  Physicians Services copay may apply.  Benefit includes mammograms and colon screenings.	Covered at 60% of R&C after deductible.  Physicians Services copay may apply.  Benefit includes mammograms and colon screenings.
Maternity Benefit	Charges for pregnancy expenses for female staff member or wife of staff member only. Coverage for pregnancy ceases when Plan coverage terminates.	\$20 copay for initial visit.  See Hospital Inpatient and X-ray/Laboratory for coverage of other expenses.  Dependent children not covered.  <i>Note: Staff must enroll newborn in plan within 31 days beginning on the date of birth.</i>	Initial visit covered at 60% of R&C after deductible  See Hospital Inpatient and X-ray/Laboratory for coverage of other expenses.  Dependent children not covered.  <i>Note: Staff must enroll newborn to plan within 31 days beginning on the date of birth.</i>
Mental Health/Substance Abuse (MH/SA)	Charges for EEX expenses rendered in a physicians office or other appropriate facility, incurred because of mental health or substance abuse. Subject to coordination of care prior to inpatient admission.	<b><u>Mental Health</u></b> <b>Inpatient:</b> \$100 copay per admission then covered at 80% after deductible to a maximum benefit of 20 days per year.  <b>Outpatient:</b> \$25 copay per visit to a maximum benefit of 30 visits per year.	<b><u>Mental Health</u></b> <b>Inpatient:</b> Covered at 60% of R&C after deductible to a maximum benefit of 20 days per year.  <b>Outpatient:</b> Covered at 60% of R&C after deductible per visit to a maximum benefit of 30 visits per year.

## MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Premera BCBS Plan	
		In-Network	Out-of-Network
		<u><b>Substance Abuse</b></u> <b>Inpatient:</b> \$100 copay per admission then covered at 80% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.  <b>Outpatient:</b> \$20 copay then 80% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period..	<u><b>Substance Abuse</b></u> <b>Inpatient:</b> \$100 copay per admission then covered at 60% of R&C after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.  <b>Outpatient:</b> \$20 copay then 60% of R&C after deductible to a maximum benefit of \$13,500 in any rolling 24-month period..
Nutritional Counseling	Covered health services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet.	\$20 copay per visit.  Nutritional therapy for conditions other than diabetes is limited to 4 visits per member per calendar year. Nutritional therapy for diabetes is not subject to a maximum limit.	Covered at 60% of R&C after deductible.  Nutritional therapy for conditions other than diabetes is limited to 4 visits per member per calendar year. Nutritional therapy for diabetes is not subject to a maximum limit.
Obesity Surgery	Charges for or in connection with surgery due to obesity.	Not covered.	Not covered.
Physician Services	Charges for professional services of physicians (unless practitioner is a family member).	\$20 copay per visit then covered in full.	Covered at 60% of R&C after deductible.
Prescription Drugs	Drugs and medicines requiring a physician's (or dentist's) prescription for a specific illness and dispensed by a pharmacist.	<u><b>Retail Pharmacy (30-day supply)</b></u> <ul style="list-style-type: none"> <li>▪ Generic: \$15 copay</li> <li>▪ Preferred: \$30 copay</li> <li>▪ Non-Preferred: \$40 copay</li> </ul> <u><b>Mail Order (90-day supply)</b></u> <u>Offered through Medco</u> <ul style="list-style-type: none"> <li>▪ Generic: \$20 copay</li> <li>▪ Preferred: \$60 copay</li> <li>▪ Non-Preferred: \$80 copay</li> </ul>	<u><b>Retail (30-day supply)</b></u> <ul style="list-style-type: none"> <li>▪ Generic: \$15 copay then 60%</li> <li>▪ Preferred: \$30 copay then 60%</li> <li>▪ Non-Preferred: \$40 copay then 60%</li> </ul>
Preventive Care	Routine physical examinations including <ul style="list-style-type: none"> <li>▪ Immunizations</li> <li>▪ Well-woman, well-man, newborn, well-baby and well-child services</li> </ul>	\$20 copay per visit then covered in full.  \$500 limit per person per calendar year not including diagnostic and screening lab services and x-rays.	Not covered.
Private Duty Nursing	Nursing services ordered by a physician and provided by or supervised by a registered nurse in your home. Benefits available only when skilled care is required. Custodial care is not covered. It is not covered when the caregiver is a member of the retiree's or dependent's family.	See Skilled Nursing Facility	See Skilled Nursing Facility

## MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Premera BCBS Plan	
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Provider Relationship	Services rendered by a person who is an immediate relative of or who ordinarily resides with the covered person requiring treatment.	Not covered.	Not covered.
Rehabilitation Services – Outpatient Therapy	Charges for the following therapies: physical, occupational, speech, pulmonary rehabilitation, cardiac rehabilitation. <i>This benefit includes massage therapy – <u>physician referral required</u>.</i>	\$20 copay per office visit to an annual maximum of 45 visits per covered person per year for all therapies combined.	Covered at 60% of R&C after deductible to an annual maximum of 45 visits per covered person per year for all therapies combined.
Sexual Dysfunction	Charges for or in connection with sexual dysfunction.	Not covered.	Not covered.
Skilled Nursing Facility	Charges by a qualified special care facility for medical care and treatment, with charges for accommodations not in excess of the rate of the facility's most common rate for semiprivate accommodations.	\$100 copay per admission then covered at 80% after deductible to maximum of 90 inpatient days per covered person calendar year if admitted within 14 days of hospitalization.	60% of R&C after deductible to a maximum of 90 inpatient days per covered person per calendar year if admitted within 14 days of hospitalization.
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy	Benefits available when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services.	\$20 copay per visit then covered in full. <ul style="list-style-type: none"> <li>Acupuncture covered to a maximum of 24 visits per covered person per year.</li> <li>Chiropractic covered to a maximum of 24 visits per covered person per year.</li> </ul>	Covered at 60% of R&C after deductible.. <ul style="list-style-type: none"> <li>Acupuncture covered to a maximum of 24 visits per covered person per year.</li> <li>Chiropractic covered to a maximum of 24 visits per covered person per year.</li> </ul>
Transplant Services	Covered for certain organ and tissue transplants to a maximum benefit of \$250,000 when ordered by a physician. Transplantation services must be received at a designated Blue Quality Centers for Excellence in the United States to be covered.	Covered as any other condition to a maximum benefit of \$250,000.  Subject to coordination of care prior to admission.	Prior approval required.
Vision—Hardware	Charges for eyeglasses, contact lenses, examination for prescription eyeglasses or contact lenses. See <i>Eye Examinations</i>	Frames, lenses, and contacts covered at 100%, to a maximum benefit of \$150 per rolling 24-month period.	Frames, lenses, and contacts: covered at 100% with a maximum benefit of \$150 per rolling 24-month period.

## MANDATED MEDICAL BENEFITS

Description of Medical Plan Coverage		In-Network	Out-of-Network
Mandated Health Benefits	<p>Federal law requires group health plans to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy if agreed to by the patient and attending physician:</p> <ul style="list-style-type: none"> <li>Reconstruction for the breast on which the mastectomy was performed.</li> <li>Surgery or reconstruction of the other breast to produce a symmetrical appearance.</li> <li>Prostheses, and</li> <li>Physical complications for all stages of a mastectomy, including</li> </ul>	Covered as required by law.	Covered as required by law.

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	swelling associated with the removal of lymph nodes. This coverage would be made available to participants or beneficiaries who are receiving benefits in conjunction with a mastectomy and who elect breast reconstruction.		
Mandated Maternity Benefits	The Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for normal or vaginal delivery or less than 96 hours for a cesarean section. However, the Plan does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan shall not require that a provider obtain authorization from the Plan of prescribing a length of stay not in excess of 48 (or 96 hours, if applicable).	Covered as required by law.	Covered as required by law.